Physician Application For Membership

AMERICAN SOCIETY FOR MOHS SURGERY

6475 East Pacific Coast Highway, Box 700
Long Beach, CA 90803-4201
Phone: (800) 616-ASMS (2767) (714) 379-6262
Fax: (714) 379-6272 (714) 362-9540

Name _____ Birthdate _____

Practice Name and Address _____

City _____ State _____ Zip _____

Office Phone _____ Office Fax _____ Cell Phone _____

E-mail _____ Web Address _____

Home Address _____

City _____ State _____ Zip _____ Country _____

Home Phone _____ CC E-mail _____

Education

Medical School _____ Year Began _____ Ended _____

Internship _____ Year Began _____ Ended _____

Dermatology Residency _____ Year Began _____ Ended _____

(International Applicants Only)
Non-Dermatology Residency _____ Year Began _____ Ended _____

Post Graduate Training _____ Total Years _____

Professional Credentials

(U.S. Applicants only)
Dermatology or Pathology Board Certification: ◯ Yes Specialty _____ Date _____ No _____

(U.S. dermatologist applicants for Affiliate or Fellow membership must attach proof of certification by either the American Board of Dermatology or the American Osteopathic Board of Dermatology, or their international equivalents. Similarly, U.S. pathologist applicants for Affiliate membership must provide certification by the American Board of Pathology, or their international equivalents. Dermatologist applicants for Associate membership must provide proof of completed ACGME accredited or AOA-approved dermatology residency training.)

(International Applicants only)
Dermatology or Non-Dermatology Board Certification:
(International dermatologist and non-dermatologist applicants for International or International Member of Distinction membership must attach proof of board certification in their respective medical specialties.)

◯ Yes Specialty _____ Date _____ ◯ No

Medical License Number(s):

_____ Date _____ State/Country _____

_____ Date _____ State/Country _____

_____ Date _____ State/Country _____

Please Indicate Appropriate Membership Category

U.S.

- ◯ Fellow Member
- ◯ Affiliate Member (Dermatologist or Pathologist)
- ◯ Associate Member
- ◯ Resident Member

International

- ◯ International Member of Distinction
- ◯ International Affiliate Member
- ◯ International Resident Member

Please describe your training in Mohs surgery: (Attach separate sheet if necessary)

_____

_____

_____

_____

(Request Separate Application Form for U.S. and International Mohs Technician Membership)

Additional Professional Data

(For the following information, you may attach a current C.V., if preferred.)

Full-Time/Part-Time Academic Affiliation(s): _____

Hospital Appointments: _____

Publications & Exhibits: _____

Membership in Other Professional Societies: _____

Areas of Research: _____

If the answer to any of the following questions is "yes", please indicate complete details on a separate sheet:

A. Has your license to practice medicine in any jurisdiction ever been limited, Suspended, or revoked? ◯ Yes ◯ No

B. Have your privileges at any hospital ever been suspended, diminished, revoked, or not renewed? ◯ Yes ◯ No

C. Have you ever been dismissed or resigned from a previous hospital medical staff? ◯ Yes ◯ No

D. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any local, state, or national medical society? ◯ Yes ◯ No

Signature: _____ Date: _____

Case Documentation Form

(To be submitted with application for U.S. Fellow or International Member of Distinction membership only)

We request documentation for a minimum of seventy-five (75) Mohs cases in which applicant was the primary surgeon. Case records must be available for review upon request.

	Patient Initials	Patient Age	Date of Procedure	Diagnosis	Site	Mohs Indication	No. of Levels
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

(Duplicate this form for remaining 60 required cases, or provide digital spreadsheet containing this information)